Safety Huddles for Learning From Close Calls

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Goals

- To understand the background and rationale (e.g. safety culture, knowledge transfer) for safety huddles
- To equip facility champions with the knowledge and tools necessary for implementing safety huddles

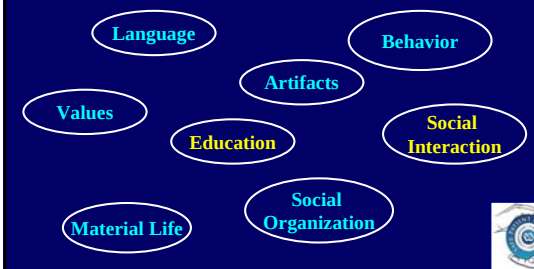
Communication & Safety

- Breakdowns in communications have been linked to medical errors and the negative effects of errors
  - When patients are not involved in patient safety (2006 JCAHO goal)
  - When leaders fail to communicate safety goals to members of the organization
  - When providers and administrators fail to communicate effectively with patients after an error
  - **When the "blame culture" dominates**
  - **When providers fail to communicate and learn from errors and adverse events**

What is Culture?

"Culture is explicit and implicit patterns of behavior that are *acquired* and *transmitted* by symbols created by humans, including their embodiments in *artifacts*. The essential core of culture consists of traditional ideas and their attached values. Culture is a product of action, and a condition of further action." (Kroeber & Kluckhorn, 1952)

Multiple Facets of Culture



The Culture of Safety: Education

"Blame" Culture	Positive Safety Culture
Imparting knowledge from authority to learner	Learning in the context of one's work
Back Injury Prevention Classes for "fixing" the caregiver	Safety Huddles for learning from tacit knowledge among co-workers

The Culture of Safety Social Interaction

"Blame" Culture	Positive Safety Culture
Top down approach	Employee Empowerment
Policy that dictates how, when and why staff will use patient handling equipment	Group of caregivers on a unit guided by a collective belief in the importance of safety, and their shared understanding that every member upholds the group's safety norms

A Positive Culture of Safety

- People avoid making the same kind of mistakes by sharing the lessons learned
- When mistakes occur people take responsibility for them
- People learn from their mistakes

Safety Huddles

- A process for:
  - transfer of tacit knowledge
  - transferring knowledge a team has learned from doing a task in one setting, to the next time that team does the task in different setting (Dixon, 2000)
- Similar processes: After Action Review, Unit Briefings, Tell a Story

Guidelines for Safety Huddles

- The group asks
  - (1) What happened?
  - (2) What was supposed to happen?
  - (3) What accounts for the difference?
  - (4) How could the same outcome be avoided the next time?
  - (5) What is the follow-up plan?

Advantages of Huddles

- Informal process
  - Official minutes are not recorded and reports are not forwarded to supervisors
  - Meetings are facilitated locally
- There is no recrimination or blame*
- Facilitating huddles requires little training
- Huddles require trust among team members but also can be used to promote trust and teambuilding*

Advantages of Huddles

- Huddles are compatible with other, more formal reporting and review processes, e.g. incident reports, root cause analysis, failure mode effects analysis
- Process is transferrable to other safety close calls*

Summary of Evaluation Data in VISN 8

- Huddle program component was probably not fully implemented – variation across 32 sites
- Huddles were perceived as the least effective part of the SPH Program (62% of UPLs rated as effective)
- Units that incorporated huddles into their operations found them
  - valuable and positive
  - An excellent method for transferring knowledge to decrease risk for staff injury

Safety Huddles and Safe Patient Handling

- Goals of Safety Huddles
  - Communication tool, to assists teams to learn from the experiences of each individual in real time
  - Provide a means to implement changes quickly
  - Take the embarrassment out of close calls
  - Involve front line staff in identifying problems and solutions, and in creating change in their work environments
  - Assist in shifting the organizations to a positive, blame-free Culture of Safety

Lessons Learned for Successful Safety Huddle Implementation

- Systematic training of UPLs and staff using interactive approaches (e.g. coaching, role playing, case study analysis)
- Incorporate safety huddles into existing patient/staff safety programs
- Gain mid-manager support

Lessons Learned for Successful Safety Huddle Implementation

- Communicate to leadership their role in successful implementation
  - Set example by openly communicating about errors and injuries – and don't tolerate blaming individuals for mistakes
  - Reward system
    - For improvements in care based on safety huddles
    - For conduct of safety huddles

Safety Huddle Implementation

- Training Tools
  - Tri-fold brochure (PDF)
  - Safety Huddle Case Study (PowerPoint)
  - Safety Huddle Tracking Form (Word Document)
  - Planned: video of mock safety huddle